SECTION 4.
INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

The Pharmacy Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. Medicaid claims should be mailed to:

Verizon Information Technologies
P.O. Box 5400
Jefferson City, MO 65102

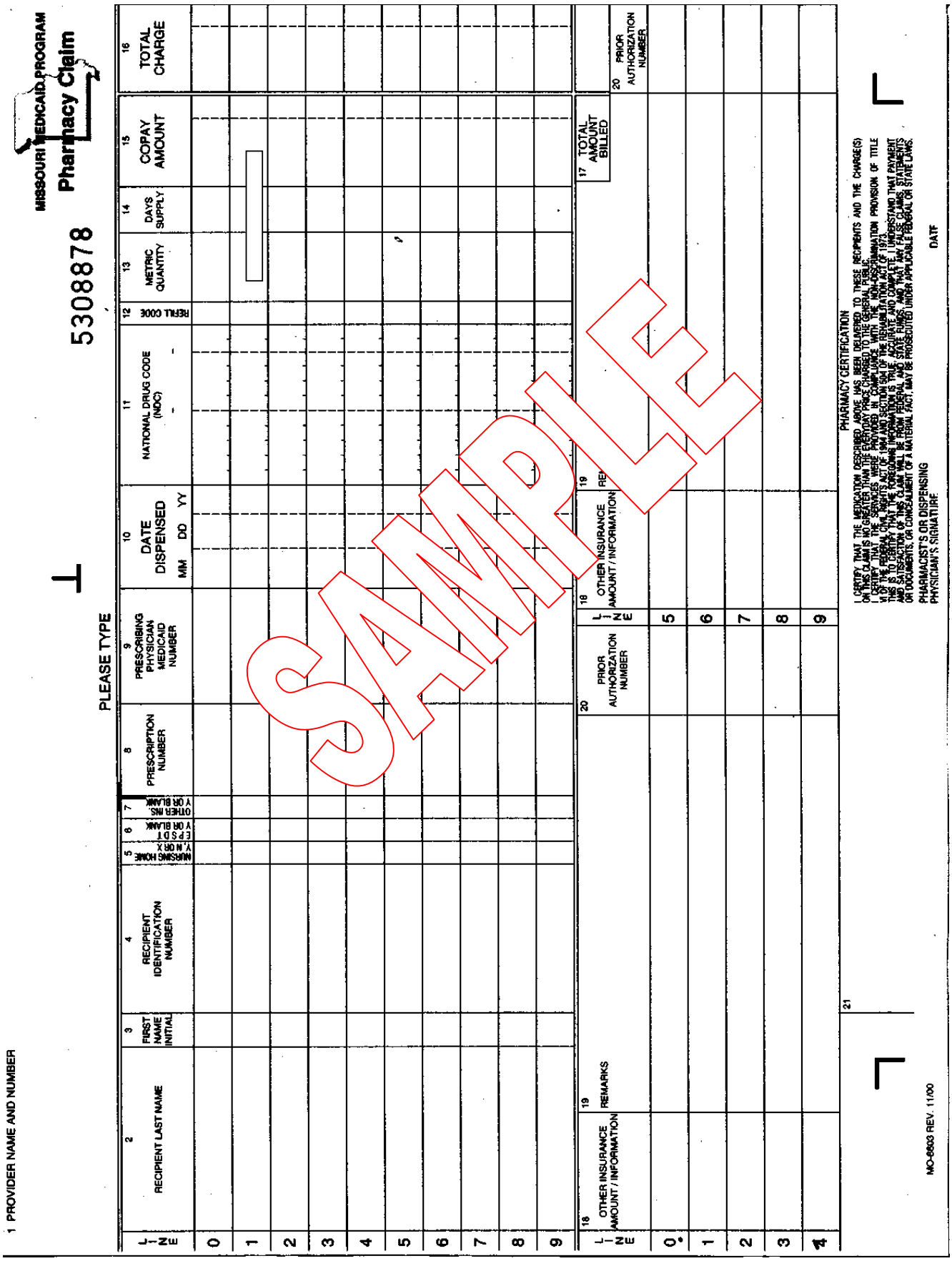
NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number & Name		Instructions for Completion
1.*	Provider Name and Number	Affix the preprinted provider label or enter the provider number, provider name and address *exactly* as it appears on the label.
2.*	Recipient Last Name	Enter the recipient's full last name.
3.*	First Name Initial	Enter the first letter of the recipient's first name.
4.*	Recipient Identification Number	Enter the Medicaid or MC+ number exactly as shown on the patient's ID card or approval letter.
5.	Nursing Home	Leave blank.
6.**	EPSDT	If the medication is administered as a result an EPSDT/HCY screening or referral, enter the letter "Y". Otherwise, leave blank.
7.**	Other Insurance	If the recipient has other insurance that covers injections, enter the letter "Y". Otherwise, leave blank. If "Y" is entered in this field, enter the name of insurance plan and the amount of the other insurance payment in field 18, Other Insurance Amount/Information.
8.*	Prescription Number	Enter a sequential identification number in this field. (Note: This number is used to sort claims

		submitted electronically on the remittance advice.) If the provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service. If no unique identifying character is added, all but the first claim denies as a duplicate.
9.*	Prescribing Physician	Enter the Drug Enforcement Administration (DEA) number or the Missouri Medicaid provider number for the provider performing the service. For injections given by advanced practice nurses, nurse midwives or other applicable health care professionals enter the Missouri Medicaid Provider number, or the DEA number of the collaborating physician.
10.*	Date Dispensed	Enter the date the injection was administered in MM/DD/YY numeric format.
11.*	National Drug Code	Enter the exact NDC assigned to the product administered as it appears on the package from which it was dispensed. Always enter the entire number, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 must be listed 00045-0143-20.
12.	Refill Code.	Leave blank.
13.*	Metric Quantity	Enter the metric quantity used in administration on as follows: Products in Solution (ampule, IV bag, bottle, syringe, vial) - bill the number of cc's (ml's) administered. Vials Containing Powder for Reconstitution - bill the number of vials used. Immunizations - bill the number of doses administered. (The quantity usually equals 1). Levonorgestrel Implant - bill a quantity of 1 (1 kit = 1 unit).

14.*	Days Supply	As the process is for billing for medications administered in the physician's office, the value for this field should always equal 1. Claims with a value other than 1 in this field are denied.
15.	Co-pay Amount	Leave blank. Do not use this field to record insurance payments.
16.*	Total Charge	Enter the provider's usual and customary charge for this service.
17.*	Total Amount Billed	Enter the sum of the line items above.
18.**	Other Insurance Amount/Information	If payment from a private insurance company has been received, use the appropriate line number(s) of the claim(s) affected, enter the name of the insurance company and the amount of the insurance payment. If the insurance company denied payment for the service, use the appropriate line number(s) of the claim(s) affected, enter the name of the other insurance, and state "denial attached". Attach a copy of the insurance explanation of benefits documenting the reason for the denial. If the insurance denied the claim because their claim filing requirements were not met, Medicaid also denies the claim. See Section 5 of the Medicaid *Provider Manual* for further information about third party liability.
19.	Remarks	Leave blank.
20.	Prior Authorization Number	Leave blank.
21.	Signature	The physician or authorized representative may sign and date the form. Hand-written or computerized signatures, or a signature stamp are acceptable.

* These fields are mandatory on all Pharmacy Claim forms.
** These fields are mandatory only in specific situations, as described.


MISSOURI MEDICAID PROGRAM
Pharmacy Claim
5308878
PLEASE TYPE
1 PROVIDER NAME AND NUMBER
LINE
2 RECIPIENT LAST NAME
3 FIRST NAME INITIAL
4 RECIPIENT IDENTIFICATION NUMBER
5 NURSING HOME Y, M OR X
6 EPSDT Y OR BLANK
7 OTHER MS. Y OR BLANK
8 PRESCRIPTION NUMBER
9 PRESCRIBING PHYSICIAN MEDICAID NUMBER
10 DATE DISPENSED MM DD YY
11 NATIONAL DRUG CODE (NDC)
12 REFIL CODE
13 METRIC QUANTITY
14 DAYS SUPPLY
15 COPAY AMOUNT
16 TOTAL CHARGE
17 TOTAL AMOUNT BILLED
18 OTHER INSURANCE AMOUNT / INFORMATION
19 REMARKS
20 PRIOR AUTHORIZATION NUMBER
21
PHARMACY CERTIFICATION
I CERTIFY THAT THE MEDICATION DESCRIBED ABOVE HAS BEEN DELIVERED TO THESE RECIPIENTS AND THE CHARGE(S) ON THIS CLAIM IS NO GREATER THAN THE EVERYDAY PRICE CHARGED TO THE GENERAL PUBLIC.
I CERTIFY THAT THE SERVICES WERE PROVIDED IN COMPLIANCE WITH THE NON-DISCRIMINATION PROVISION OF TITLE VI, SECTION 504 OF THE REHABILITATION ACT OF 1973, AND THE AGE DISCRIMINATION ACT OF 1975.
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE
DATE
MO-8603 REV. 11/00
SAMPLE